Medication Therapy Management (MTM) program

Provider Operations Manual

Tennessee | Medicaid

This operating manual outlines the Medication Therapy Management (MTM) program guidelines and policies effective November 1, 2024.

General information

Background

In 2022, TennCare authorized the design and implementation of the MTM program as a cost-effective alternative (CEA) to improve therapeutic outcomes by optimizing responses to medication, managing treatment-related interactions or complications, and improving adherence to drug therapy.

The MTM program has been defined as a distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product.

TennCare members eligible to receive program services are identified based on specific criteria and specific disease-targeted states (pediatric members with asthma or diabetes mellitus).

Pharmacists participating in MTM will provide MTM services under a ***Collaborative Practice Agreement*** *(CPA)* with TennCare Patient Centered Medical Home (PCMH) and Tennessee Health Link organizations to help patients maximize the benefit from their medications. The goal of MTM is to work with patients to actively manage their drug therapy by identifying, preventing, and resolving medication-related problems.

The services provided to members by a qualified Tennessee MTM pharmacist may include:

1. Patient assessment (medical history as related by the patient)
2. Comprehensive patient medication therapy review
3. Personal medication record (to be retained by the patient)
4. Medication action plan (for the patient to follow)
5. Document problems, resolutions, education, and evaluation of a patient's responses to medication therapy including adverse events; and
6. Follow-up to ensure patient adherence with a medication action plan and to encourage patient self-management

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MTM services will be provided to eligible members participating in a PCMH or Health Link (which are part of a Tennessee Health Care Innovation Initiative focused on value by providing high-quality and cost-effective care). Qualified MTM pharmacists for TennCare will be required to establish and maintain a working relationship with the PCMH and/or Health Link members.

Parameters and design

Framework

The MTM program will function as a CEA:

- Participation in the MTM program is **voluntary** for PCMH for TennCare and Health Link.
- Pharmacists must meet minimum requirements and have a CPA with a PCMH for TennCare or Health Link.
- TennCare members will be eligible for MTM services based on MTM criteria developed using) risk stratification criteria for critical, high, medium-high, moderate status, and **Targeted-Disease States** (TDS) (for example, pediatric members with asthma or diabetes mellitus).
- During the initial MTM appointment, the pharmacist will conduct a member history interview and perform a medication regimen evaluation. The MTM pharmacist will address the member's understanding of medications and how they help manage their disease, adherence difficulties, inhaler techniques, adverse drug reactions, drug interactions, identification of any inappropriate drug therapy, as well as any member medication concerns.
- Following the initial visit, a report summarizing the MTM visit will be sent to the member's PCMH or Health Link. Per the professional judgment of the MTM pharmacist, copies of the report may be sent to other medical providers (for example, specialists) who may have prescribed medications to the member.
- The reimbursement model is based on a **per member, per month (PMPM) case rate**for eligible TennCare members. Payment limits are based on the service description (based on MTM criteria) unless an exception is granted. Payment for services is contingent on continued TennCare eligibility.
- At each visit, the MTM pharmacist will deliver to the member educational resources (or handouts), a personalized medication list, and medication guidance.
- Following every MTM encounter, the pharmacist will document notes and outcomes. The pharmacist will provide the PCMH/Health Link with a complete and up-to-date medication list, a summary report of the visit, and any recommendations for potential changes to the current drug regimen, when appropriate.
- Communications between the pharmacist and PCMH or Health Link organizations is crucial and should be open, collaborative, and continue throughout the program.

MTM requirements

PCMH or Health Link requirements

The MTM program is voluntary specifically for practices who are participating in the PCMH for TennCare and Health Link initiative.

A PCMH or Health Link must establish a written CPA with a qualified Tennessee pharmacist. The CPA is a great opportunity for the practice to establish pharmacist expectations, scope of practice, and parameters related to MTM services.

The pharmacist is required to document all encounters related to MTM services. As such, the PCMH or Health Link will need to help facilitate any necessary EHR/EMR onboarding of the pharmacist(s) as a new user within the team process.

Pharmacist requirements

Pharmacist(s) must meet the following criteria to qualify as a MTM Pharmacist for TennCare:

1. Pharmacists must have a valid Tennessee license and meet minimum insurance requirements (for example professional liability).
2. The participating pharmacist must acquire their own TennCare Medicaid ID.
    a. Information on provider registration and how to access the provider portal can be found on the TennCare Provider Registration website at: **tn.gov/tenncare/providers/provider-registration.html**
    b. **Important**: Individual providers will submit information that will place the provider on the Council for Affordable Quality Healthcare (CAQH) roster for TennCare/Tennessee Medicaid. Information and links, including a FAQ document, can be located at the website above. Once data is received from CAQH and approved, a Medicaid ID will be assigned. Note that TennCare will also automatically receive your profile data from CAQH each time you make an update.
    c. CAQH: **https://proview.caqh.org/Login/Index?ReturnUrl=%2f**
    d. For more information concerning provider registration please contact Provider.Registration@tn.gov by email or by calling **800-852-2683**, option 5.
3. MTM pharmacists must have a written formal CPA in place with a PCMH for TennCare or Health Link organization.
    a. The CPA establishes pharmacists to prescribing providers (supervising physicians)
    b. Expectations from the scope of practice to documentation. The Tennessee Board of Pharmacy rules can be located at the following webpage: **http://publications.tnsosfiles.com/rules/1140/1140-03.20170220.pdf**
    c. CPA guidance and minimum requirements can be located at: **capitol.tn.gov/Bills/108/Amend/SA0839.pdf**
    d. Additional information on CPA requirements can be located at the Tennessee Pharmacy Association (TPA) webpage: **tnpharm.org/wp-content/uploads/FINALTPACPA-guidance.pdf**
4. The MTM pharmacists participating in the MTM program must document in the EHR/EMR.
5. MTM pharmacists must engage and complete the MCO credentialing and network agreements.
    a. See **Section 3.3**
6. Availity Essentials access will be granted after the MCO credentialing and network process is completed.
7. Acceptable *Use Policy and Remote Access Request Forms* (electronic process) must be signed.

8. **All** registration steps listed above must be completed **prior to** providing MTM services and submitting claims for reimbursement.

3.3. MTM network contract

MTM pharmacists participating in the MTM program are required to engage and complete credentialing and sign the network agreement. Pharmacists should contact Provider Solutions to initiate the process:

- Website: provider.wellpoint.com/tennessee-provider/home
- Phone: **800-454-3730**

4. Member eligibility

4.1. Member (patient) eligibility

TennCare members qualify for MTM services if they have a primary care provider (PCP) participating in a PCMH for TennCare or Health Link organization and have specific health risk problems or targeted disease states. An example might include a member who is categorized as high-risk based on multiple chronic illnesses and taking multiple medications.

Member eligibility with risk stratification and TDS logic is described in **Section 4.5**.

4.2. General stratification

MTM eligibility criteria fall into the general program categories:

1. MTM-High CDPS-High Critical (members who have been identified with a risk stratification of critical and high)
2. MTM-High CDPS-Medium High
3. MTM-Moderate CDPS
4. Pediatric Asthma
5. Pediatric Diabetes Mellitus

4.3. Risk design

The MTM program uses the Chronic Illness and Disability Payment System plus Pharmacy (CDPS + Rx) which combines medical diagnoses and prescription drugs to develop risk scores used within the attribution file. The diagnostic classification system was developed by Richard Kronick and Tod Gilmer at the University of California (UC)-San Diego to help Medicaid programs measure illness burden and adjust calculated capitation rates to health plans that enroll Medicaid beneficiaries. All cost for a population is accounted for in the model through claims. Members without any diagnosis category will be given a baseline for age/sex risk score. This type of scoring often happens more frequently with children. CDPS + Rx do provide separate models for different populations (for example, adults vs children, disabled vs TANF, and different covered services). Relative risk weights are internal to each model and determined from separate claims data sets for each model (adults vs children) and reflect actual diagnosis and treatment patterns in the separate populations used to develop each distinct model and its calculated weights. Thus, identical diagnosis histories will produce different risk scores between, for example, adults and children.

An individual's risk score is the additive sum of the age/sex base rate and the risk weights for each separate diagnosis category. Additional weight may be included for the interaction of two diagnosis categories where significant synergies have been identified.

For additional information on risk adjustment methodology, please see the following websites: http://cdps.ucsd.edu/ and https://tinyurl.com/m8c2xbfz

4.4. *MTM Identification (or Eligibility) Criteria: Risk Stratification and Targeted Disease State*

MTM hierarchy logic

Member eligibility criteria for the MTM program have been divided into three risk categories: CDPS-High Critical, CDPS-Medium High, and CDPS-Moderate Risk, and two TDS defined as pediatric DM and pediatric asthma. In addition, the MTM program has set age eligibility parameters for each of the MTM service categories.

The MTM hierarchy logic first differentiates members by 1) risk stratification classifications (CDPS + Rx), followed by 2) MTM-specific age criteria, and then 3) targeted disease state for pediatric members with either asthma or DM who do not fall into the exclusion criteria. For example, if a pediatric member has asthma and does not fall into one of the risk stratification categories (e.g. critical) then the pediatric member would be assigned to the asthma TDS.

It is important to note the MTM stratification categories are mutually exclusive and as such the member should only appear in one service category.

General MTM stratification

General MTM stratification will display in the attribution file as **MTM-High CDPS-High Critical**, **MTM-High CDPS-Medium High**, or **MTM-Moderate CDPS** program status:

1. **MTM-High CDPS-High Critical:**
    a. **MTM-High CDPS-High Critical** program identifies two risk levels (critical and high) as eligible for MTM services. Members identified in **MTM-High CDPS-High Critical** include members with the age parameters of two years and 0 days to 64 years 364 days qualify for MTM services. In addition, pediatric patients who have diagnoses of asthma and/or DM (with high or critical risk) will be identified as **MTM-High CDPS-High Critical**.
2. **MTM-High CDPS-Medium High:**
    a. **MTM-High CDPS-Medium High** program status will identify those patients who have medium-high risk status as eligible for MTM services. In addition, pediatric patients who have diagnoses of asthma and DM (either with moderate, low, or no risk) will be identified as **MTM- High CDPS-Medium High** program status. Additionally, pediatric patients who have diagnoses of asthma or DM (with medium-high) will identify as **MTM-High CDPS-Medium High**. Members identified in **MTM-High CDPS-Medium High** include members with the age parameters of two years and zero days to 64 years 364 days qualify for MTM services.

        The MTM program will also focus on two TDS that do not qualify in the **MTM-High CDPS- Medium High** category.

3. **MTM-Moderate CDPS:**
    a. **Moderate CDPS** program status includes patients with a risk stratification superior to low and inferior to medium-high. Members in the **Moderate CDPS** category are aged two years and zero days to 64 years and 364 days. The **Moderate CDPS** program encompasses patients with a moderate risk stratification without a diagnosis of diabetes mellitus and/or asthma, pediatrics, or otherwise.
4. **MTM-Pediatric Diabetes:**
    a. **MTM-Pediatric Diabetes** will be displayed in the attribution file for pediatric members (with moderate, low, or no risk) who have DM as defined by the ICD-10-CM codes listed below. This category includes only members identified with age parameters between the ages of two years and zero days to 17 years and 364 days. If a pediatric member has both DM and asthma diagnoses, they will be assigned to either the **MTM-High CDPS-High Critical** or **MTM-High CDPS-Medium High** category dependent on risk stratification.

        The diagnoses (ICD-10) codes include in the **MTM-Pediatric Diabetes**:
        i. E08.XX (all) - Diabetes mellitus due to underlying condition
        ii. E09.XX (all) - Drug or chemical-induced diabetes mellitus
        iii. E10.XX (all) - Type 1 diabetes mellitus
        iv. E11.XX (all) - Type 2 diabetes mellitus
        v. E12.XX (all) - Malnutrition-related diabetes mellitus
        vi. E13.XX (all) - Other specified diabetes mellitus
        vii. 024.XX (Gestational diabetes in pregnancy)

Table 4.1: Program status indicator and risk classification example

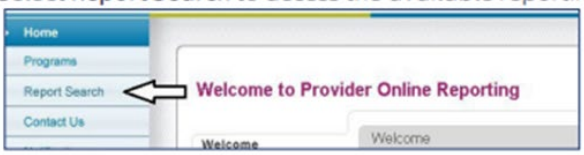
Example	Diagnosis	Risk	Program status indictor[1]
Member one	Asthma, Diabetes* (pediatric)	Low	MTM-High CDPS-Medium High
Member two	None	Critical	MTM-High CDPS-High Critical
Member three	Pediatric Diabetes	Low	MTM-Pediatric DM
Member four	None	Moderate	MTM-Moderate CDPS

[1]**Rule outcome*con**

4.5 How to access attribution file in Availity Essentials

The MTM eligibility indicator is located on the attribution file and is updated once per month.

Select **Report Search** to access the available reporting section available to you.



Select the area of reporting to view Patient Center Medical Home (PCMH) or Tennessee Healthy Links (THL). *Access includes all reporting categories in the dropdown, some will not apply to PCMH.* Need assistance? Visit the **Custom Learning Center** in Payer Spaces to view Provider Online Reporting job aids in the resources section.

Select the weekly attribution report (per TennCare specifications). The MTM eligibility indicator will be located to the right end of the report for both programs (column AA for PCMH, and column AE for THL)

MTM Eligbility
Y
Y
Y
Y
N
Y

5 Policy and procedures

PCMH for TennCare, Health Link, and MTM pharmacists shall at all times act in accordance with state and federal laws when providing MTM Services to TennCare enrollees, and in a manner so as to assure quality of those services, including guidelines, rules, and policies as outlined in the MTM policy for TennCare and procedures provided in this manual. MTM pharmacists are responsible for adhering to all program updates provided by email, through the TennCare updates, Wellpoint provider manual for billing guidelines, and website.

5.1 PCMH, Health Link, and pharmacist expectations

1. MTM visits will be conducted in collaboration with a TennCare designated Patient Centered Medical Home (PCMH) or Health Link.
2. A participating TennCare designated PCMH or Health Link must establish a CPA with an MTM qualified pharmacist to provide MTM services to MTM eligible members for TennCare.
3. TennCare members cannot receive MTM services from more than one MTM designated pharmacist for TennCare at one time.
4. The MTM pharmacist for TennCare must provide the MTM service in collaboration with a PCMH for TennCare or Health Link.
5. The MTM pharmacist for TennCare will schedule MTM services appointments and conduct MTM visits in a private, distraction free environment:

   a. Secure Wi-Fi and network connections are required.
   b. The use of public Wi-Fi is prohibited (for example, Starbucks).
   c. Conducting indirect services in a public area is prohibited.
6. Pharmacists must not provide MTM services in the dispensing area of the pharmacy.
7. Pharmacists must not be performing other duties at the time of member MTM visit including dispensing.
8. To avoid conflicts of interest between dispensing and clinical activities, the pharmacist providing MTM services cannot be the only pharmacist scheduled on duty at the pharmacy:
   a. Exception is if a pharmacy only dispenses at a specified time. For example, prescription dispensing is scheduled from 8 a.m. to 12 p.m. MTM services may be provided to members during non-dispensing activities, 1 to 5 p.m.
   b. May schedule members before or after retail hours.
9. The MTM pharmacist for TennCare should be fully prepared to conduct the MTM visit at the time of the member's appointment. The time required to prepare for the visit is not billable.
10. It's required that the MTM pharmacist document and complete the required MTM services.
    a. **Exception**: Based on federal regulations (*CFR 42 Section 2*), pharmacists are prohibited from documenting medication-assisted therapy drugs, such as buprenorphine used to treat opioid addiction, due to privacy requirements.
11. Each MTM-designated pharmacist for TennCare must retain a permanent record of the MTM encounter documentation and other documentation pertinent to the visit in accordance with federal and state medical record retention regulations.
12. Verify the member's MTM eligibility before each visit by using the Availity. The system is updated with member eligibility information on Health Link. For more information on MTM eligibility, please see **Section 4.4**:
    a. If a patient is no longer eligible for MTM services, the MTM pharmacist may contact the member and inform him/her of the change in MTM eligibility status. Members may be directed to contact TennCare with any questions regarding their MTM service eligibility.
13. The MTM pharmacist will check the member's ID (photo identification, TennCare ID, or participation invitation letter) to confirm and identify MTM program eligibility.
14. The MTM pharmacist for TennCare will:
    a. Document member assessment including pertinent medical history.
    b. Conduct a comprehensive medication therapy review which should document the member's use of all medications, including OTCs, herbals, and supplements as relayed by the member.
    c. Prepare the member's MTM summary report.
    d. Coordinate and assist the member in obtaining other health care resources (e.g., asthma coalitions) and provide pertinent materials to assist members in managing their conditions.
    e. Document drug therapy problems, recommended solutions, education, and evaluation of member's response to therapy.
    f. Schedule follow-up appointments, as needed, to ensure member medication adherence in order to determine if the member's goals have been met.
    g. Collaborate and preserve a working relationship with member's PCMH for TennCare or Health Link.
    h. Provide the member with a copy of the MTM summary report.

15. The MTM pharmacist will enter all documentation from the visit into the members health record. The time required to document the visits are not billable.
16. The TennCare pharmacist will maintain a collaborative relationship with the member's PCMH or Health Link, including sending written summaries and recommendations of all MTM encounters.
17. PCMH or Health Link must be contacted for all interventions that require immediate attention.
18. All written and verbal contacts must be documented in the member's record. Pharmacist must send a permanent record of MTM encounters via a secure method to member's PCMH/Health Link (or prescriber's) health record:
    a. CPA may include additional guidance or outline documentation policies with procedures to ensure MTM documentation is retained and becomes a permanent part of the member's health record (for example, EHR).
19. MTM pharmacists should communicate any recommendations to PCMH or Health Link.
20. Medication recommendations by the MTM pharmacist should be based upon professional judgment and evidence-based guidelines. The MTM pharmacist should be familiar with the disease states and medications included in the recommendation and should refer to available evidence and guidelines:
    a. Sample references and a list of member resources can be located in **Appendix 6**.
21. The MTM pharmacist for TennCare may bill using designated TennCare electronic claims processing systems such as a clearing house, website, or may submit a bill using a paper claim using the designed MTM service modifiers and CPT® codes. Methods of claim submission are dependent on Wellpoint policies.
22. General Information:
    a. MTM pharmacists are required to follow all established TennCare guidelines, rules, and policies.
    b. MTM pharmacists may work for more than one TennCare-designated PCMH or Health Link.
    c. Reimbursement for MTM services will cover a per month case rate that includes an initial face-to-face, one-on-one visit with the TennCare member. Follow-up on Health Link case rate visits may be done face-to-face or indirectly (for example, telephonically) at the member's preference:
        i. Group visits are not permitted as part of the one-on-one MTM service for reimbursement. However, outside of the one-on-one visit, group education sessions may be conducted during the month as an integral part of care and
        ii. interaction with the member (without additional MTM Program reimbursement).
        iii. The time required for the preparation of the MTM visit is not reimbursable.
        iv. Time required for follow-up/reminder telephone calls is not reimbursable.
        v. Pharmacists cannot submit a claim for no-show appointments.
    d. Reimbursements for MTM services are based on established case rates with service limits.
    e. TennCare members cannot receive MTM services from more than one MTM pharmacist for TennCare at a time.

6 Additional expectations

6.1 Member expectations:

1. The MTM program will select members based on specific risk and TDS criteria and offer eligible TennCare members MTM services.
2. TennCare members are expected to attend scheduled appointments.
3. TennCare members cannot receive MTM services from more than one MTM pharmacist at a time (during a month).
4. There are no member payments for MTM services for TennCare.

6.2 FQHC and RHC expectations

An MTM service involving behavioral health medications does not constitute a second visit due to FQHC/RHC rules on what constitutes a visit and is paid for outside regular RHC/FQHC payment methodology.

See *TennCare Policy* for additional FQHC/RHC information.

7 Record retention, security, and compliance

7.1 Record retention and security

All MTM service encounter documentation (for example, comprehensive medication assessments) must be retained by the pharmacist for the required number of years as outlined by federal and state laws. The method of retention should comply with all federal and state HIPAA requirements. It is the MTM pharmacists' responsibility to retain documentation of MTM services delivered and should be readily available for audit requirements.

7.2 Compliance and legal regulations

Provider(s) agree to recognize and abide by all state and federal laws, rules, regulations, and guidelines applicable to the *Agreement* and the Medicaid program. Including but not limited to, Section 6032 of the Deficit Reduction Act of 2005 (DRA) with regard to policy development, employee training, and whistle-blower protection related to The False Claims Act, 31 USCA § 3729-3733, et seq., the Tennessee State Plan, 42 CFR § 431.107, 42 CFR 455 subpart B, TCA §53-10-304, and TennCare rules.

7.3 Incorporation by reference to federal and state law/regulation

The *Agreement* incorporates by reference all applicable federal and state laws and regulations, and any applicable court orders or consent decrees. All revisions of such laws or *State of Tennessee Medicaid Policy and Guidelines*, regulations, court orders, or consent decrees shall automatically be incorporated into the *Agreement* as they become effective.

8 Reimbursement methodologies

8.1 Activity requirements

Qualified MTM pharmacists are eligible for reimbursement based on a **per-month case rate** for one-on-one encounter visits with TennCare members enrolled in the MTM program.

A pharmacist provides individual management therapy with assessment and intervention. This patient-specific service includes the review of the pertinent history and profiling of prescription and non-prescription medications. The pharmacist evaluates the medication profile for under or overdosing, duplication, and possible drug interactions and makes recommendations based on the assessment, including communication with the prescriber. Pharmacists should provide ongoing evaluation and monitoring to ensure optimal medication treatment. This information is then documented and included in the PCMH or Health Link Health Record.

8.2 Reimbursement information

The payment model for the MTM is designed to reimburse at a **per-month case rate** based on the risk stratification or targeted disease state of the TennCare member. Remember, MTM pharmacists may have as many interactions throughout the month as needed with members.

The MTM service modifier codes for TennCare (which identify the case rate) and payment limits are as follows:

Table 8.2: MTM service modifiers and limits

Service description	Modifier	Case rate	Payment limits (per year)	Case units[2] (per month)
Targeted Disease State (juvenile asthma and diabetes)	U1	$55.00	Two months	One unit for each case rate
Medium High	U2	$55.00	Three months	One unit for each case rate
Critical	U3	$75.00	Six months	One unit for each case rate
High	U3	$75.00	Six months	One unit for each case rate
Moderate	U5	$55.00	Two months	One unit for each case rate

[2]Use appropriate CPT code for service (for example, encounter).

8.3 How to file a claim

Reimbursement for MTM services will cover a per month case rate that includes an initial face-to-face, one-on-one visit with the TennCare member. Follow-up on Health Link case rate visits may be done face-to-face or indirectly (for example telephonically) at the member's preference. The initial case rate is based on a minimum of at least 15 minutes per month:

- The CPA between the PCMH/Health Link and MTM pharmacist may offer organizational requirements and expectations regarding MTM service delivery.

As part of MTM **reporting and tracking**, the pharmacist must use professional claim (CMS - 1500) for billing MTM services and use the required CPT codes to submit for MCO reimbursement. It is important for participating pharmacists to submit the following CPT© code(s) to identify the MTM service in conjunction with the service modifier (case rate) to properly receive reimbursement payments.

The MTM program uses the CPT code description to identify medication therapy management service for reporting and tracking time associated with MTM services for reimbursement are:

- **CPT 99605**: MTM services provided by a pharmacist, individual, face-to-face with the patient, with assessment and intervention if provided; initial 15 minutes, **new patient**
- **CPT 99606**: MTM provided by a pharmacist, individual, face-to-face with the patient with assessment and intervention if provided; initial 15 minutes, **established patient**
- **CPT 99607**: MTM provided by a pharmacist, individual, face-to-face with the patient, with assessment and intervention if provided, **each additional 15 minutes** (list separately in addition to code for primary service).

CPT 99605 code is used for new patients and is only allowed once per member for MTM. To understand the difference between a new and established patient, please refer to the CPT handbook. In addition, a brief definition of a new and established patient can be found in **Section 10: Definitions and Acronyms**.

The use of CPT 99607 is an add-on code for tracking each additional 15-minute increments of time spent with the member providing MTM services. Remember, add-on codes must be accompanied by either 99605 or 99606. **It is important to know the CPT 99607 code is used for information only and no additional reimbursement is associated with this code.**

Submission of this code is required so that Wellpoint can track member usage patterns for purposes of the program. **Recall, the MTM program is only reimbursing pharmacists a per month case rate based on a service modifier**.

Only one case rate payment will be made per member per month based on the pharmacist who submits the first claim for the billing month.

Pharmacists will follow customary reimbursement and place of service (POS) guidelines. CMS *POS Code Set* can be found at cms.gov/Medicare/Coding/place-of- service-codes/Place_of_Service_Code_Set.html. Example: POS 11 for MTM service provided in the PCMH or Health Link office. POS 53 for MTM service provided in a CMHC. POS 02 for MTM services provided telephonically.

If MTM services are provided by indirect (or telephone) services, the call must be interactive in real time (voicemails, text messages, and/or emails to enrolled members are not billable encounters). Indirect services must be completed in a private area. To identify indirect (telephone) MTM services for tracking and reporting, the pharmacists are required to use the following CPT codes for reimbursement:

- **CPT 98966**: Telephone assessment and management services provided by a qualified non-physician healthcare professional to an established patient, parent, or guardian not originating

from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 5 to 10 minutes of medical discussion.

- **CPT 98967:** Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 11 to 20 minutes of medical discussion.
- **CPT 98968**: Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 21 to 30 minutes of medical discussion.

8.4 General billing requirements

MTM Pharmacists must bill according to usual and customary standards:

1. Pharmacists must verify TennCare member MTM program eligibility on the attribution file.
2. Must use professional claim (*CMS-1500*) for billing MTM services
3. The **NPI of the pharmacist** who performed the service should be reported in the rendering provider ID field.
4. In cases where the billing and rendering provider are the same, the rendering (performing) provider information should not be reported. However, it is required when the rendering provider information is different from the billing provider. The billing provider should contain the employer's tax ID and NPI on the claim as required per NUCC billing standards and X12 5010 requirements:
    a. Please reference the *Division of TennCare IS Policy, Provider Identification Usage on Submitted Transactions* which can be located at: tn.gov/content/dam/tn/tenncare/documents/provideridentificationusage. pdf
5. The appropriate POS must be submitted with claims (for example, POS 11 for MTM services provided in an office; POS 53 for service provided in a Community Mental Health Center):
    a. See CMS and MCOs for additional information and guidance.
    b. POS 02 must be used in conjunction with CPT codes 98966, 98967, or 98968.
    c. An MTM service involving behavioral health medications does not constitute a second visit for purposes of the FQHC/RHC rules on what constitutes a visit and is paid for outside regular RHC/FQHC payment methodology. See TennCare policy for additional FQHC/RHC information.
6. The MTM CPT code(s) are used for reporting and tracking for reimbursement. To appropriately track time and use of resources for MTM services. CPT codes 99605-99607 are time-based and submitted in 15-minute increments. 99607 billing code (is an add-on) and must be used in conjunction with 99605 and 99606. Please note that the CPT 99607 code is for informational purposes only and does not impact the claims payment.

7. The service description modifier (for example, U3 = critical/high risk) must be used to identify the covered MTM service and case rate:
   a. Frequency limitations are associated with each service category modifier.
   b. See **Table 8.2** for the service modifier and limit description.
8. Verify the number of MTM service visits. Case rates will not be paid past the limits as described in this section:
   a. For example, pediatric members with a diagnosis of asthma that stratify into the TDS category have an MTM service limit of two months.
   b. See **Table 8.2** for the service modifier and limit description.
9. Members who change risk categories (in other words, from medium-high to critical) are eligible for service limits equal to the higher risk service payment limit:
   a. For example, a member's initial risk is evaluated at medium-high but is later re-evaluated and risk-adjusted to critical. The member would convert from the medium-high to high-risk service limit. Any previous MTM services would count toward the high-risk service payment limit for the year.
10. Only one case rate payment will be made per member per month based on the pharmacist who submits the first claim for the billing month.
11. Reimbursement for initial MTM services will only cover face-to-face, one-on-one contact with the member. Follow-up MTM non-Health Link visits may be done face-to-face or indirectly (telephonically) at the member's preference.
12. If the member switches pharmacists in the middle of the year the limit will follow the member (in other words, high-risk level member had two visits with the first pharmacist, and the new pharmacist only has four visits remaining).
13. The MTM service claim must be submitted within the timely filing guidelines outlined in the provider manuals to be reimbursed.
14. If MTM service is provided by indirect (telephone) services:
   a. The telephone call must be interactive in real-time.
   b. Voicemails, text messages, and/or emails to enrolled members are not billable encounters.
   c. 98966, 98967, or 98968 must be used for reimbursement.
      i. POS 02 must be used in conjunction with CPT codes 98966, 98967, or 98968.
15. The MTM service claim must include the referring/ordering/prescribing provider and NPI to receive reimbursement.
16. **Appendix 4: Billing, Reporting, and Tracking MTM Service Sample Chart**
17. The pharmacist will maintain a collaborative relationship with the member's PCMH or Health Link, including sending written summaries and recommendations of all MTM encounters.
18. PCMH or Health Link must be contacted for all interventions that require immediate attention.

19. All written and verbal contacts must be documented. Pharmacists must send a permanent record of MTM encounters via a secure method to the member's PCMH/Health Link (or prescriber's) health record:
    a. CPA may include additional guidance or outline documentation policies with procedures to ensure MTM documentation is retained and becomes a permanent part of the member's health record (for example, EHR).
20. MTM pharmacists should communicate any recommendations to PCMH or Health Link.
21. Medication recommendations by the MTM pharmacist should be based upon professional judgment and evidence-based guidelines. The MTM pharmacist should be familiar with the disease states and medications included in the recommendation and should refer to available evidence and guidelines:
    a. Sample references and a list of member resources can be located in *Appendix 6*.
22. The MTM pharmacist may bill using designated TennCare electronic claims processing systems such as a clearing house, MCO website, or may submit a bill using a paper claim or handwritten claim using the designed MTM service modifiers and CPT codes.
23. General information:
    a. MTM pharmacist(s) are required to follow all established TennCare guidelines, rules, and policies.
    b. MTM pharmacist may work for more than one TennCare designated PCMH or Health Link.
    c. Reimbursement for MTM services will cover a per month case rate that includes an initial face to face, one-on-one visit with the TennCare member. Follow-up on Health Link case rate visits may be done face-to-face or indirectly (such as telephonically) at the member's preference:
        i. Group visits are not permitted as part of the one-on-one MTM service for reimbursement. However, outside of the one-on-one visit, group education sessions may be conducted during the month as an integral part of care and interaction with the member (without additional MTM Program reimbursement).
        ii. Time required for preparation of the MTM visit is not reimbursable.
        iii. Time required for follow-up/reminder telephone calls is not reimbursable.
        iv. Pharmacist cannot submit a claim for no-show appointments.
    d. Reimbursements for MTM services for TennCare are based on established case rates with service limits.
    e. TennCare members cannot receive MTM services from more than one MTM pharmacist at a time.

8.5 Additional information

For additional information on billing procedures, please contact the individual MCO:

- Provider manual: https://tinyurl.com/u3ptm3e9:
  - MTM claims submission instructions: https://Availity.com

- Select **Register** in the upper right corner
- When registered, you can access the Availity Essentials *Learning for Web Portal*
- In this section, pharmacists can access tools to walk them through claims submission for Wellpoint. Screenshot below.
- Other functionality on Availity Essentials includes:
  - Eligibility inquiries
  - Claim status inquiries
- To start the electronic claims submission process or if you have questions, please contact our EDI Hotline at **800-590-5745**.
- Availity support is available at **800-Availity (800-282-4548)** or Support@availity.com

9 How will quality and efficiency be measured?

9.1 MTM quality metrics

Quality metrics will be based on PCMH/Health Link metrics, Star measure rating, and HEDIS®.

10 Definitions and acronyms

CAQH: Coalition for Affordable Quality Healthcare

Case Rate: A payment method in which a flat amount covers a defined service or group of services.

CEA: Cost-effective alternative

Comprehensive medication review: Systemic review and evaluation of patient's medication regimen, encompassing prescription and OTC agents. Includes any actions or recommendations needed to optimize treatment.

CPT billing increments: For the MTM program, one unit (one billing increment) will equal 15 minutes spent with a member for MTM services.

CPT: Current Procedural Terminology

Dual eligible: Refer to members (beneficiaries) who qualify for both Medicare and Medicaid benefits. Established Patient: An established patient has received professional services from the physician/qualified health care professional or another physician/qualified healthcare professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

EHR: Electronic health record

EMR: Electronic medical record

EOB: The *Explanation of Benefits* is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. The *EOB* typically describes the service performed, the date of service, the amount of the provider's fee and insurer allowable, and any adjustments with reasons.

Face-to-face: Face-to-face time for services is defined as only the time spent face-to-face with the patient and/or family. This includes time spent performing such tasks as obtaining a history and counseling the patient.

FQHC: Federally qualified health center

HIPAA: *Health Information Portability and Accountability Act*

ICD-10-CM: International Classification of Disease, Tenth Revision, Clinical Modification is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with healthcare in the United States.

MTM: Medication Therapy Management

NPI: National provider identifier is a *HIPAA* administration simplification standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).

New patient: A new patient has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

OTC: Over-the-counter

PCP: Primary care provider

PCMH: Patient Centered Medical Home

POS: Place of service

RHC: Rural health clinic

Health Link: Tennessee Health Link

TMR: Targeted medication review

TDS: Targeted disease states

MTM pharmacist: The pharmacist designated by Wellpoint who can conduct and submit claims for MTM services and has a collaborative practice agreement with a TennCare-designated PCMH or Health Link.

11 MTM questions and answers for TennCare:

1. Can I provide the member with additional educational information?

   Yes. If a pharmacist feels that the member would benefit from additional educational information, you may select material based on professional judgment.

2. Can I bill for my time if the member did not show up for their scheduled appointment?

   No. Only time spent with a member can be billed. If a member fails to show, then the time is not payable.

3. Can I bill for my preparation time to get ready for the MTM visit?

   No, preparation time should not be billed (only time spent directly with the member can be billed).

4. Are all members eligible for MTMservices?

   No. Only members that meet the MTM eligibility criteria can receive MTM services. Availity will help to identify members' program status eligibility. Patients are eligible if they meet risk categories (members with multiple chronic conditions and multiple medications) or pediatric members diagnosed with asthma or diabetes mellitus.

5. Can a patient's caregiver attend the MTM visit with the patient?
   Yes, with the patient's permission.

12 Contact information and other resources

Provider website for Wellpoint:

- provider.wellpoint.com/tennessee-provider/home

Primary Care Transformation:

- tn.gov/tenncare/health-care-innovation/primary-care- transformation.html

Information Systems Policies for TennCare:

- tn.gov/tenncare/policy-guidelines/information-systems-policies.html

Division of TennCare IS Policy Manual:

- tn.gov/content/dam/tn/tenncare/documents/provideridentificationusage.pdf

13 List of appendices

Appendix 1: Reimbursement guidelines

Appendix 2: AH and MTM crosswalk

Appendix 3: Billing, reporting, and tracking MTM service sample chart

Appendix 4: Resources and references

Appendix 1: Reimbursement guidelines

MTM reimbursement guidelines: The case rates for MTM covered services are described below:

Service description	Modifier code	Case rate	Payment limits	Units
Targeted Disease States (Juvenile Asthma or Diabetes)	U1	**$55.00**	2 months	1 unit for each case rate
Medium-High Risk	U2	**$55.00**	3 Months	1 unit for each case rate
Critical, High Risk	U3	**$75.00**	6 Months	1 unit for each case rate
Moderate Risk	U5	**$55.00**	2 Months	1 unit for each case rate

CPT codes will be used to indicate the services that the member received:

CPT code	CPT code description
99605	Medication therapy management service(s) provided by pharmacist, individual, **face-to-face** with patient, with assessment and intervention if provided; **new** patient visit, initial 15 minutes
99606	Medication therapy management service(s) provided by pharmacist, individual**, face-to-face** with patient, with assessment and intervention if provided; **established** patient visit, initial 15 minutes
99607	Add-on code for each additional 15-minute increment
98966	**Telephone** assessment and management services provided by a qualified non-physician health care professional to an established patient. 5-10 minutes
98967	**Telephone** assessment and management services provided by a qualified non-physician health care professional to an established patient. 11-20 minutes

CPT code	CPT code description
98968	**Telephone** assessment and management services provided by a qualified non-physician health care professional to an established patient. 21-30 minutes

Pharmacists will bill the appropriate CPT code (99605 for a new patient or 99606 for an established patient) in conjunction with the service modifier to receive appropriate case rate reimbursement. To track and report time, if a visit lasts more than 15 minutes, the pharmacist will also submit 99607 with an additional unit for each 15-minute increment. Please note, the CPT 99607 code is for informational purposes only and does not impact the claims payment. MTM services provided by Indirect (telephone) must be submitted using 98966, 98967, or 98968.

Only one Case Rate payment will be made per member per month based on the pharmacist who submits the first claim for the billing month. If a member switches pharmacists in the middle of treatment the limit will follow the member (for example, a high-risk level member had two visits with the first pharmacist. The new pharmacist only has four visits remaining). Members who change risk categories (for example, from medium-high to critical) are eligible for service limits equal to the higher-risk service payment limit.

The claim must be submitted within the timely filing guidelines outlined in the provider administration manual.

Billing examples:

- High-Risk Level member:
  - Example one: New High-risk member has a one-hour visit with a pharmacist in January:
    - Bills 99605, Modifier U3
    - Bills 99607 x3
  - Example two: The same member as above has a 15-minute visit with a pharmacist in February:
    - Bills 99606, Modifier U3
  - Example three: The same member as above has a 30-minute visit with a pharmacist in March:
    - Bills 99606, Modifier U3
    - Bills 99607
  - Example four: The same member as above has a 45-minute visit with a pharmacist in April:
    - Bills 99606, Modifier U3
    - Bills 99607, x 2
- Medium-High Level member:
  - Example five: A new medium-high level member has a 30-minute visit with the pharmacist in March:

  - Bills 99605, Modifier U2
  - Bills 99607
- Example six: The same member as above has a 30-minute visit with the pharmacist in April:
  - Bills 99606, Modifier U2
  - Bills 99607
- Example seven: The same member as above has a 15-minute visit with the pharmacist in May:
  - Bills 99606, Modifier U2

- Targeted Disease States Level Member:
  - Example eight: A new Targeted Disease States level member has a 30-minute visit with the pharmacist in March:
    - Bills 99605, Modifier U1
    - Bills 99607
  - Example nine: The same member as above has a 30-minute visit with the pharmacist in April:
    - Bills 99606, Modifier U1
    - Bills 99607
  - Example ten: The same member as above has a one-hour visit with the pharmacist in May:
    - Bills 99606, Modifier U1, U4 and Bills 99607, x 3

Appendix 2: Crosswalk: *AH Risk Stratification File* and MTM reimbursement

Crosswalk between the MTM_MCO_Data file and reimbursement document									
	Targeted disease states (TDS) and risk stratifications								
Availity Essentials	Asthma (Yes) Low or Moderate Risk (pediatric)	DM (Yes) Low or Moderate Risk (pediatric)	Asthma and DM (pediatric) Low, moderate, and medium high	Asthma and DM (pediatric) High or Critical Risk	Critical	High	Medium-High	Moderate	Low
Reimbursement	TDS	TDS	Medium High	High	Critical	High	Medium-High*	Moderate	N/A
# Maximum services (per year)	2	2	3	6	6	6	3	2	N/A

Crosswalk between the MTM_MCO_Data file and reimbursement document									
	Targeted disease states (TDS) and risk stratifications								
Modifier	U1	U1	U2	U3	U3	U3	U2	U5	N/A

(*This change was implemented to be consistent between AH and Billing reimbursement terminology. Note, this was previously designated as moderate for reimbursement)

Appendix 3: Billing, reporting, and tracking MTM service

Sample chart:

MTM example	Time (minutes)	Location	CPT	CPT (add-on)	POS[1] service code	MTM modifier[3]
New, Critical	45	Office	99605	99607 x2	11	U3
New, High	30	CMHC	99605	99607	53	U3
Est, Asthma	15	Office	99606		11	U1
Est, Asthma	15	Indirect[2]	98967		02	U1
Est, Medium-High	30	Indirect[2]	98968		02	U2
Est, DM	45	f/u office	99606	99607 x2	11	U1
New, Moderate	30	CMHC	99605	99607	53	U5

[1] CMS *Place of Service Code Set* is available at: https://cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

[2]The telephone call must be to a member and must be associated with MTM services. The telephone call must be interactive. Voicemails, text messages, and/or emails to enrolled members are not billable encounters.

[3] MTM case rate or service modifier.

Appendix 4: Sample* resources for the MTM program

Tennessee
Tennessee Department of Health Website: https://tn.gov/health
Medicaid.gov: https://medicaid.gov/medicaid/by-state/stateprofile.html?state=tennessee

Tennessee Medicaid Program-Preferred Drug List: https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Tenncare-PDL-Oct.pdf
TennCare/Pharmacy Division: https://tn.gov/tenncare/providers/pharmacy.html
OptumRx/TennCare Pharmacy Program: _https://optumrx.com/oe_tenncare/landing
State Link: https://tn.gov
Asthma
National Asthma Education and Prevention Program: https://nhlbi.nih.gov/health-topics/asthma
Asthma NHLBI quick reference guide 2011: https://nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Asthma NHLBI clinical guidelines 2007: https://nhlbi.nih.gov/sites/default/files/media/docs/asthgdln_1.pdf
Asthma Management program: https://www.childrens.com/specialties-services/specialty-centers-and-programs/pulmonology/programs-and-services/asthma-program/asthma-management-program
COPD
COPD GOLD 2017 clinical guidelines: http://goldcopd.org/gold-2017-global-strategy-diagnosis-management-prevention-copd/
COPD Gold pocket guide 2017: http://goldcopd.org/wp-content/uploads/2016/12/wms-GOLD-2017-Pocket-Guide.pdf
Heart Disease
American Heart Association: http://heart.org/HEARTORG/
Tennessee Heart & Vascular: https://tennheart.com/service/heart-failure
2013 ACCF/AHA Guideline for the Management of Heart Failure Guidelines: http://circ.ahajournals.org/content/128/16/e240
2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: http://onlinejacc.org/content/70/6/776?_ga=2.148619383.158575615.1515514627-331575729.1495415471
Diabetes Mellitus
AACE/ACE Guidelines: https://aace.com/files/dm-guidelines-ccp.pdf
AACE/ACE diabetes algorithm: https://aace.com/files/aace_algorithm.pdf
ADA Standards of Medical Care in Diabetes 2017: https://professional.diabetes.org/sites/professional.diabetes.org/files/media/dc_40_s1_final.pdf
American Association of Diabetes Educators: https://diabeteseducator.org/prevention
Children's Diabetes Program: http://childrenshospital.vanderbilt.org/interior.php?mid=729

East Tennessee Pediatric Endocrinology: https://etch.com/Specialties/Pediatric-Endocrinology.aspx
Strategies for Insulin Injection Therapy in Diabetes Self-Management: https://diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/research/aade_meded.pdf?sfvrsn=2
Comprehensive Foot Examination and Risk Assessment: http://care.diabetesjournals.org/content/31/8/1679
Hypercholesterolemia
National Human Genome Research Institute: https://genome.gov/25520184/learning-about-familial-hypercholesterolemia/
American Heart Association: http://heart.org/HEARTORG/Conditions/Cholesterol/Cholesterol_UCM_001089_SubHom ePage.jsp
2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: http://circ.ahajournals.org/content/circulationaha/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf
Lifestyle Full Work Group Report: http://circ.ahajournals.org/content/suppl/2013/11/07/01.cir.0000437740.48606.d1.DC1
Triglycerides and Cardiovascular Disease: http://circ.ahajournals.org/content/123/20/2292
National Lipid Association 2014 guidelines: https://lipid.org/recommendations
Hypertension
Hypertension Management Program: http://fepblue.org/en/wellness-resources-and-tools/wellness-resources/hypertension-mgmt-program/
Hypertension Institute: http://hypertensioninstitute.com/
2017 High Blood Pressure Clinical Practice Guideline: http://www.onlinejacc.org/content/accj/early/2017/11/04/j.jacc.2017.11.006.full.pdf
2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk: http://circ.ahajournals.org/content/circulationaha/early/2013/11/11/01.cir.0000437740.48606.d1.full.pdf
Mental Health
American Psychiatric Association guidelines: https://psychiatry.org/psychiatrists/practice/clinical-practice-guidelines
DSM-5 ICD codes: https://psychiatry.org/psychiatrists/practice/dsm
Migraine
American Academy of Neurology: http://patients.aan.com/disorders/
American Headache Society: http://ahspicme.com/
Clinical Practice Guideline for Chronic Headache 2013: http://jhsnet.org/english/guideline2013.pdf

Myocardial Infarction
American Heart Association: http://heart.org/HEARTORG/
ACC Clinical Guidelines NSTEMI: http://onlinejacc.org/content/64/24/e139?_ga=2.103077440.1750408609.1515607605-393126105.1515607605 STEMI: http://onlinejacc.org/content/61/4/e78?_ga=2.7149170.1750408609.1515607605-393126105.1515607605
2011 AHA_ACCF Secondary Prevention Update: http://circ.ahajournals.org/content/circulationaha/124/22/2458.full.pdf
Smoking Cessation
American Lung Association: http://lung.org/stop-smoking/
Tobacco Control Initiative in Davidson County: http://nashville.gov/Health-Department/Tobacco-Control.aspx
Smoking Cessation: https://bluecare.bcbst.com/Health-Programs/Smoking-Cessation.html
Smoking Cessation Program: http://tristarcentennial.com/service/smoking-cessation-program/
Treating Tobacco Use and Dependence AHRQ 2008: https://ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/index.html
Treating Smokers in Healthcare Settings: http://nejm.org/doi/full/10.1056/NEJMcp1101512
Stroke
The Heart Attack and Stroke Prevention Center: http://theheartattackandstrokepreventioncenter.com
Brain and Spine Institute: https://utmedicalcenter.org/brain-and-spine-institute/medical-services/stroke-center/
AHA/ASA Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack: http://stroke.ahajournals.org/content/45/7/2160

* Sample of reference and is not considered an all-inclusive list